## From the Surgeon General

## DHHS BLUEPRINT FOR ACTION ON **BREASTFEEDING**

DAVID S. SATCHER, MD, PHD SURGEON GENERAL

During the past 15 years, the Office of the Surgeon General has highlighted the public health importance of breastfeeding, but it wasn't until late last year that we released a science-based action plan to increase breastfeeding rates in the United States.

The Blueprint for Action on Breastfeeding calls for more education, awareness, support, and research to change breastfeeding patterns.

We know breastfeeding is one of the most important contributors to infant health, and that it offers economic benefits to the family, health care system, and workplace. Despite these benefits, however, breastfeeding rates are surprisingly low, especially at six months postpartum. In 1998, the year for which the most recent statistics are available, only 29% of all mothers breastfed six months after birth. Rates are especially low among African American women. We, as a nation, must address these low breastfeeding rates as a public health challenge and put in place culturally appropriate breastfeeding promotion strategies.

The Blueprint recommends, "Infants should be exclusively breastfed during the first 4 to 6 months of life, preferably for a full 6 months. Ideally, breastfeeding should continue through the first year of life." It also recommends specific action steps to be taken by the health care system, the workplace, the family, and the community; it identifies several areas of research. Recognizing that breastfeeding rates are influenced by various factors, these recommendations suggest that those interested in the health of infants in both the public and private health arenas forge partnerships to promote breastfeeding. We understand that community norms and traditions play a role in the decision to breastfeed and have designed these recommendations to adapt to specific needs at the local level.

The *Blueprint* says we must better educate community health specialists, the public, and the health professions on the health benefits of breastfeeding. Extensive research on the biology of human milk and health outcomes has established that breastfeeding is more beneficial than formula feeding. Breastfed infants ex-



perience fewer cases of infectious and noninfectious diseases as well as less severe cases of diarrhea, respiratory infections, and ear infections. Breastfeeding also reduces the risk of overweight in children. Mothers who breastfeed experience less postpartum bleeding, earlier return to pre-pregnancy weight, and a reduced risk of ovarian cancer and pre-menopausal breast cancer.

We must also send the message that breastfeeding saves money for families. In a year's time, families can save several hun-

dred dollars they might otherwise spend on breast milk substitutes. They can also save on medical care costs since breastfed infants typically require fewer sick care visits. Employers also benefit since breastfed infants are sick less often. It is interesting to note that maternal absenteeism rates are significantly lower in companies with established lactation programs.

To encourage breastfeeding, the health care system should support the training of health care professionals on the basics of lactation counseling and management, and establish hospital and maternity center practices that promote breastfeeding. We cannot realistically promote breastfeeding without making comprehensive, up-to-date, and culturally tailored lactation services available to all women.

The Blueprint also recognizes the importance of family and community support for women making decisions about breastfeeding. During prenatal and postnatal visits, we should be educating women, their partners, and other significant family members on the benefits of breastfeeding. We must find creative ways to encourage fathers and other family members to be actively involved throughout the breastfeeding experi-

We also need to address the breastfeeding challenges for mothers who return to the workplace. A large proportion (70%) of employed mothers who have children younger than age 3 work full-time. About one-third of these mothers return to work after three months. We should establish family and community programs that enable breastfeeding continuation when women return to work, and facilitate on-site breastfeeding or breast milk expression. Employers should offer flexible work hours, job sharing, adequate breaks, and education for personnel about why their breastfeeding co-workers need support. The workplace can With a large number of infants enrolled in childcare, it is also important that childcare facilities be supportive of breastfeeding. Childcare centers should make accommodations for mothers who wish to come in and breastfeed, or be supportive of mothers who want their children to be fed expressed milk.

Above all, we must send a message that breastfeeding is normal, desirable, achievable, and a natural part of community life. To that end, the *Blueprint* recommends a widespread public health marketing campaign to encourage development of community support beyond the health care setting. This could include the development of information resources for breastfeeding women such as hotlines, peer counseling, and mother-to-mother support groups. The Office on Women's Health has begun development of a high profile campaign to promote breastfeeding, targeting African American women in particular.

The Blueprint recommendations should be viewed in the context of our overall health goals for the nation. Since 1979, we have set 10-year health objectives for the nation in the Healthy People initiative. The Healthy People breastfeeding objectives for the year 2000 were not met, however. These objectives were to increase to 75% the proportion of mothers who breastfed their babies in the early postpartum period, and to increase to 50% the proportion of mothers who breastfed their babies through 5 to 6 months of age. In 1998, only 64% of all mothers breastfed in the early postpartum period and only 29% breastfed at 6 months postpartum. Specifically, 45% of African American mothers breastfed their infants in the early postpartum period, compared with 66% of Hispanic mothers and 68% of white mothers. No group of women reached the breastfeeding objective for 5 to 6 months postpartum (50%), and again, disparities existed across racial and ethnic groups (19% of African American mothers breastfed, 28% of Hispanic mothers, and 31% of white mothers). In Healthy People 2010, an additional objective was added for 25% of mothers to breastfeed their babies through the first year of infancy. In 1998, only 9% of African American, 17% of Hispanic, and 19% of white mothers met this objective.

A number of reasons might explain why so few African-American mothers breastfeed. Breastfeeding is not always viewed positively in the African American community, although there are some grass-roots efforts underway to change that image. We have learned that it is often difficult for African American women to receive information and education about breastfeeding, to have breastfeeding initiated in the hospital, to continue breastfeeding in the early days in the home setting, and to continue breastfeeding for an extended period. It is also true that African American mothers tend to return to work earlier (eight weeks) than Caucasian mothers and have jobs that are not hospitable to breastfeeding.

Development of the Blueprint for Action on Breast-feeding began in 1998 when the Environmental Health Policy Committee asked the DHHS Office on Women's Health to lead the Subcommittee on Breastfeeding in this effort. Subcommittee members include represent-atives of several federal health agencies as well as private sector healthcare professional organizations. Upon reviewing available research studies on breastfeeding, the Subcommittee recommended that we close research gaps and gain a better understanding of the social, cultural, economic, and psychological factors that influence infant feeding behaviors, especially among African American and other minority and ethnic groups.

They also recommended that we monitor breast-feeding incidence and duration trends to help us judge our success in improving breastfeeding rates. The *Blue-print* also pointed out that there has not been enough research on factors that interact with the decision to breastfeed, including the role of fathers, the influence of brief postpartum hospital stays, the safety of over-the-counter and prescription products taken by breastfeeding mothers, and the effects of breast implants on childhood disorders.

As medical technologies advance at breathtaking speed, the *Blueprint* reminds us that so far there is little that can improve on what nature intended for the nurture and sustenance of the human infant. We can, however, improve the way we deliver that message to all segments of society, and we can create a national environment that better facilitates and encourages breastfeeding.

For a copy of the *Blueprint*, visit the DHHS/OWH website at http://www.4women.gov or call 800-994-9662 or TDD 888-220-5446.

Address correspondence to: Surgeon General David S. Satcher, MD, PhD, US Public Health Service, US Department of Health and Human Services, 5600 Fishers Lane, Room 18-66, Rockville, MD 20857.